VERMONT
QUALIFIED HEALTH PLAN & QUALIFIED DENTAL PLAN PREMIUM PROCESSING POLICY & OPERATIONS GUIDANCE
2022

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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Section 1: Introduction

1.1 Overview:

With the change from centralized billing through the Exchange to individual issuer billing, this document intends to consolidate information that previously existed in multiple locations into a single resource document. The Issuer Policy & Operations Guide is created in close collaboration with Vermont's issuer partners and it will be updated as necessary in future years.

1.2 Purpose:

This document provides policy and operational guidance related to premium billing and payment functions for the Vermont health benefits exchange. Content relates to policies, technical requirements and process flows discussed at length throughout the Premium Processing Transition Project with sign-off from each issuer. The document's format is primarily narrative with references to applicable federal and/or Vermont law, to technical requirements and to graphical illustration of processes where applicable.

1.3 Audience:

This document is for informational purposes, targeted primarily toward issuers of Vermont qualified health plans (QHPs) and qualified dental plans (QDPs), their trading partners and third-party administrators. The document is also intended as a useful reference for prospective new issuers for the Vermont's health insurance marketplace and other stakeholders. This document may be amended from time to time to reflect changes in the law or operational requirements. This document does not create any legal rights for or obligations to enrollees.

1.4 Content:

The guide is divided into sections to address particular billing-related topics. Each section contains the following components:

- An overview providing information about the section's purpose
- A descriptive narrative briefly describing operational expectations and timing
- Federal and/or State of Vermont citations if applicable
- Pre-conditions: description of what is required in advance of the function addressed in the section
- Post-conditions: description of what is expected as a result of the function addressed in the section
- Technical requirements: as reviewed and approved during the Premium Processing Transition project work
- Process flow diagrams (if applicable): as reviewed and approved during the Premium Processing Transition project work

Section 2: Initial Billing

2.1 Overview:

This section describes the processes involved in billing and payment for a customer's initial enrollment either during the annual open enrollment period, or mid-year as the result of a qualifying event for a special enrollment period. Following the format described in the *Introduction*, the *Initial Billing* section includes a narrative description of the topic, a list of the related federal and State of Vermont citations, relevant business requirements (if applicable), pre and post conditions (if applicable), and process flow diagrams. For *Initial Billing* section, topics include methods of payment, invoice content and initial due date, binder payments, coverage effectuation and coverage cancellation.

2.1.1 Initial Billing Related Business Rules & Functional Requirements:

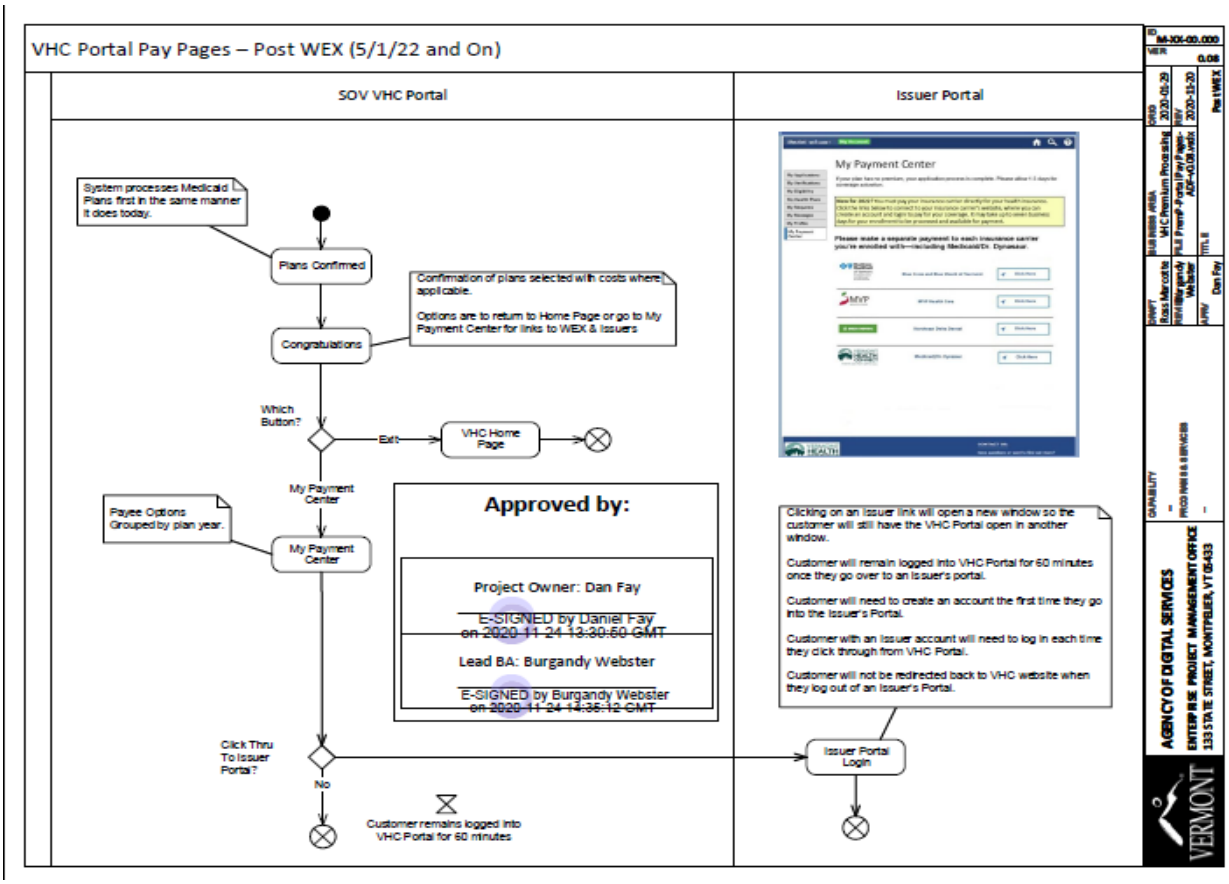
Req ID or BR ID	Formal Re-Write
BR-INVOIC-00009	Issuers must assume responsibility for the invoicing and processing of QHP premium payments beginning with Plan Year 2022.
BR-PAYPGS-00001	Customer portals must include: amount due, payment due date and consequences for not paying.
BR-PAYPGS-00002	The "My Payment Center" page must provide instructions to the customer on how to pay prior plan year balances, Medicaid plans, or Issuers for QHP plans.
2422	TRANSITIONAL - Issuers must be able to process legacy QHP Premium 820 files which include legacy VPA, until 6-30-2022.

2.2 Methods of Payment:

Following federal rules, Vermont issuers must accept paper checks, cashier's checks, money orders, EFT, and all general-purpose pre-paid debit cards for premium payment. Issuers may also accept credit card payments; however, administrative fees may not be charged to customers.

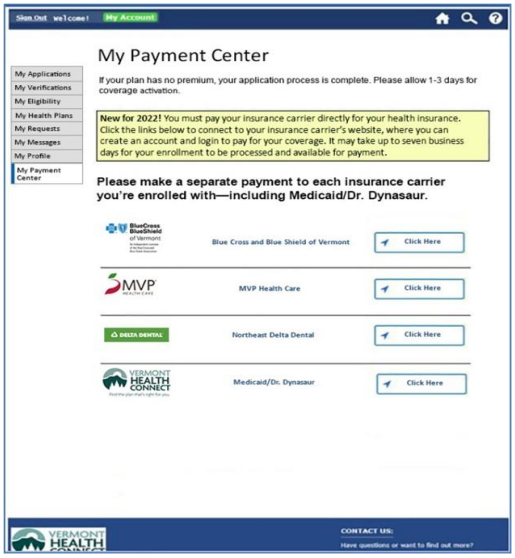
Citations: 45 CFR § 156.1240(a)

2.2.1 Portal Pay Pages Future State Process Flow:



2.2.2 Attachments:

Below is a screen shot of the My Payment Center from the Vermont Health Connect website to illustrate customer access to the payment pages for all issuers. From Requirement 2502:



2.3 Invoice Content:

Premium invoices for medical coverage must include the following detail: full premium amount, subsidy amount (as a combination of APTC and VPA or separate amounts), and the (net) individual amount due. Display of both individual subsidy figures for Advanced Payment of Premium Tax Credits (APTC) and Vermont Premium Assistance (VPA) is preferred.

Premium subsidy does not apply to dental plans on the Vermont marketplace. Upon enrollment, dental plan issuers must provide billing information to enrolled customers including the household's full monthly premium amount and due dates.

Citations: 45 CFR § 156.460(a)

2.3.1 Invoice Content Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
BR-INVOIC-00010	Issuers must include VPA value on member invoices.
BR-INVOIC-00014	Coverage and subsidy changes received from VHC must be reflected on subsequent invoices.
BR-INVOIC-00019	The customer's responsible amount must equal the monthly premium due by the customer on their invoice. The total amount due on an invoice may include past due balances.

2.4 21 Day Minimum for Premium Payment Due Date:

Issuers must provide no less than 21 days between the date an invoice is sent and the payment due date. For initial invoices produced immediately following a customer's plan selection, issuers need to provide a due date at least 21 days after the invoice date. Regular monthly invoices must also include the 21-day minimum between invoice date and payment due date.

Citations: 8 V.S.A. § 4089h

2.5 Binder Payment:

Refer to Section 2.6.1 below for description of ***effectuation*** requirements following binder payment).

(Also refer to Section 2.5.1 for description of ***binder payment*** requirements during the annual open enrollment period)

Citations: 45 CFR § 155.400(e), 45 CFR § 155.420(b)(2)

2.5.1 Binder Payment Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
BR-INVOIC-00001	The amount owed for binder payment represents a plan's first month premium.
BR-INVOIC-00005	An initial invoice is the same as a binder invoice.
BR-INVOIC-00013	A binder invoice must be generated and sent to the new enrollee within 3 business days of plan confirmation by customer.
2469	Issuers must generate an initial binder invoice for new enrollees within 2 business days of receipt of enrollment from VHC.

2470	Issuers must send an initial binder invoice to new enrollees within 2 business day of receipt of enrollment from VHC.
2471	A binder invoice must show the amount owed by the member.
2472	A binder invoice must show subsidies granted to the member, either as individual subsidies or as a total subsidy line.

2.6 Effectuation:

A customer's coverage will be effectuated by the issuer following receipt of the first premium invoice amount due from the customer. Issuers shall not delay effectuation until receipt of federal or State of Vermont subsidy, if any, which is paid to issuers separately on behalf of eligible customers.

Citations: 45 CFR § 155.400(e)

2.6.1 Effectuation Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
BR-EFFECT-00001	Full receipt of QHP binder payment must trigger 834 effectuation to VHC.
BR-EFFECT-00002	A new QHP enrollment requires a binder payment to effectuate coverage.
BR-EFFECT-00003	The member must pay the initial (binder) payment for plan coverage to be active (effectuated).
BR-EFFECT-00004	The Issuer must adhere to the 834 confirmation specifications found in the Vermont Companion Guide.
BR-EFFECT-00005	Customer's effectuation status cannot be impacted by VPA payment or processing status post 2021.
BR-EFFECT-00006	Issuers must send an 834 effectuation for each successfully processed 834 transaction received from VHC.
BR-NEWNRL-00001	Re-instated members are required to make a binder payment to effectuate QHP coverage.
BR-RENEWAL-00003	Renewed members are not required to make a binder payment to effectuate QHP coverage.
BR-SUBPAY-00004	Customer's effectuation status cannot be impacted by VCSR payment or processing status post 2021.
2435	Issuers will send VHC an 834 effectuation upon full receipt of customer binder payment for plan years Post-2021.
2478	Issuer's system must effectuate coverage for new enrollees when binder payment is received.

2.7 Cancellation:

Issuers may cancel as never effective a customer's application for coverage due to non-payment of the initial premium invoice. Cancellation applies to all household members seeking enrollment within an enrollment transaction.

Citations: 45 CFR § 155.400(e)

2.7.1 Effectuation Cancellation Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
BR-SUBPAY-00056	Record level rejections and cancellations must be reported to VHC after the Roster File is successfully processed.
BR-SUBPAY-00057	Vendor must communicate to VHC Team when the record level rejections and cancellations report is available in the reporting system for each processed roster file.
2359	Roster File rejection and cancellation report must be reported to SOV when data is added to the reporting system

Section 3: Ongoing Billing

3.1 Overview:

This section describes the various processes for routine monthly billing following a customer's initial full payment of the first month's invoice and coverage effectuation. The major topics covered in this section include a description of Vermont's prospective billing requirement, invoice due date (also described in the Initial Billing section), an overview of VPA, grace periods for subsidized and full-pay customers, late payment (dunning) notices, topics related to invoicing such as mid-year updates, mid-month, zero-dollar, partial month invoices with premium pro-ration, and payment thresholds.

3.2 Prospective Billing:

Monthly premium billing for QHPs is one month prospective. Issuers may determine a specific day to send invoices each month and must provide a minimum of 21 days between invoice date and premium due date. For example, a monthly invoice mailed on the 6th of March for April coverage, must have a due date no sooner than March 27th.

Citations: **8 VSA 4089h**

3.3 Invoice Due Date:

Issuers may determine a due date for display within monthly invoices that is a minimum of 21 days after the invoice date. Generally, issuers determine payment timeliness based on the payment postmark date for payments made by mail, or receipt date for electronic payments. Payment received by the last day of the month in which it is due are considered on-time. For example, a payment received by the issuer on April 30 for May coverage is on-time, even if the due date within the invoice is a few days earlier in April.

3.4 Invoice Content:

Invoices must provide the customer with the following information each month:

- The full premium amount for the household
- Subsidy applied (if any)
- Net premium due for the household

Citations: **45 CFR 156.460(a)**

3.4.1 Invoicing Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
BR-INVOIC-00002	Past due balance data must be maintained at the member level.
BR-INVOIC-00009	Issuers must assume responsibility for the invoicing and processing of QHP premium payments beginning with Plan Year 2022.
BR-INVOIC-00019	The customer's Responsible Amount must equal the monthly premium due by the customer on their invoice. The total amount due on an invoice may include past due balances.
BR-SUBPAY-00003	Customer's billing status cannot be impacted by VCSR payment or processing status post 2021.
BR-SUBPAY-00004	Customer's effectuation status cannot be impacted by VCSR payment or processing status post 2021.
BR-INVOIC-00014	Coverage and subsidy changes received from VHC must be reflected on subsequent invoices.
2468	Issuer's system must maintain past due balances for each subscriber from 1-1-2022 forward.

3.5 Vermont Premium Assistance (VPA):

VPA is for individual customers applying for coverage through Vermont's health insurance marketplace to provide additional premium subsidy of 1.5% beyond Advance Payment of Tax Credits (APTC). VPA applies to medical coverage only, not dental. To qualify, the household income must be below 300% of the federal poverty level (FPL). Eligible customers will receive this additional subsidy automatically through premium reduction. Within 834 enrollment transactions, the marketplace will notify issuers of the VPA amount which is to be deducted from the monthly premium amount owed by the customer. Issuers will be reimbursed monthly by the State of Vermont for the total VPA deducted from premium for their enrollees. The billing status of customers receiving VPA may not be impacted by the timing of payment remittance from the State of Vermont to the issuers.

Citations: Health Benefits Eligibility and Enrollment (HBEE), Part 7, § 60.01

3.5.1 VPA Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
BR-INVOIC-00010	Issuers must include VPA value on member invoices.
BR-INVOIC-00011	Issuers must only apply VPA value to coverage for policy years after 2021.
BR-INVOIC-00012	Customer's billing status cannot be impacted by VPA payment or processing status post 2021.
BR-INVOIC-00020	Customer's effectuation status cannot be impacted by VPA payment or processing status post 2021.

3.6 Dunning Notices:

If a customer's premium remains unpaid by the due date, issuers must provide customers with a dunning notice containing full information regarding the customer's grace period status, actions required to exit grace periods and consequences of non-payment as required under Vermont law.

Citations: **8 VSA 4089h, 8 VSA 4077 (S.88)**

3.7 Grace Periods:

3.7.1 Unsubsidized Customers:

QHP customers not receiving subsidy are given a one-month grace period with claims paid during the grace period month. To exit a grace period, a customer must pay the full premium due including both the past due and current amount. Coverage for customers with unpaid premium following the one-month grace period is terminated effective the last day of the grace period month.

Citations: 8 VSA 4077 (S. 88 2021)

3.7.2 Subsidized Customers:

QHP customers receiving premium subsidy for medical coverage are provided a grace period of 3 consecutive months. (NOTE: premium subsidy does not apply to dental plans on the Vermont insurance marketplace, therefore, only the one-month grace period described in 3.7.1 above applies to dental plan customers). Claims are paid for subsidized customers in their first grace period month; issuers may pend claims during the customer's second and third grace period months. To exit a grace period, a customer must pay the full premium due including both the past due and current amount. Coverage for customers with unpaid premium following the grace period of three consecutive month is terminated effective the last day of the first grace period month. Customers receiving only VPA are considered subsidized and therefore are entitled to receive a grace period of 3 consecutive months.

Citations: 45 CFR 156.270(d)

3.7.2.1 Grace Periods Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
BR-GRACE-00001	Members with subsidies will be given a grace period of 3 months to pay overdue balances.
BR-GRACE-00002	Members without subsidies will be given a grace period of 1 month to pay overdue balances.
BR-GRACE-00003	TRANSITIONAL - Issuers shall continue to send delinquency notices through November 2021
BR-GRACE-00004	For customers renewing with the same issuer, issuers must terminate coverage when their grace period spans coverage years and they do not pay their current year balance
BR-GRACE-00005	For customers renewing with the same issuer, issuers must cancel renewed members for the next plan year when their grace period spans coverage years and they do not pay their prior year balance.
BR-GRACE-00007	Issuers must terminate members for non-payment effective the last day of their first month of grace.

BR-GRACE-00008	Issuers must send the customer a notice of termination that includes the effective date of termination, within a week when terminating their coverage throughout the year including during the renewal period.
BR-GRACE-00009	A member must be able to renew coverage with the same Issuer while they are in grace and are subject to grace period rules.
BR-GRACE-00010	A member in grace must be able to renew in a different plan, with the same issuer during Open Enrollment.
BR-GRACE-00011	A member in grace must be able to select coverage with a different issuer for the next plan year during Open Enrollment. From the issuer perspective this will appear as a new enrollment.
BR-GRACE-00012	Issuers may choose to apply a HOLD code to claims for members who are in months two and three of a grace period for subsidized households.
BR-GRACE-00013	TRANSITIONAL - For the transition between coverage years 2021-2022, customers renewing coverage with MVP will be granted a new grace period beginning in January 2022, separate from past due balances in 2021.
BR-GRACE-00014	Issuers must apply payments to past due balances first for PY 2022 and beyond.
BR-GRACE-00015	Issuers must manage grace periods across coverage years for PY 2022 and beyond.

3.8 Updating Customer Invoices:

Issuers must update customer invoices in a timely manner to reflect any changes in premium amount, subsidy and net premium due. This is generally done in the invoice following the month in which the change is processed.

Citations: 45 CFR 156.460(a), 45 CFR 155.340(a)

3.8.1 Mid-Month Invoices:

Mid-month invoices are not generated by issuers for enrolled Vermont health insurance marketplace customers. Changes in premium amount, subsidy or net premium due are reflected in the invoice following the month in which the change is processed. Changes in full premium, subsidy and net premium due may be updated on the issuer's customer billing portal in advance of the next month's invoice.

3.8.2 Zero-Dollar Invoices:

Vermont issuers have discretion whether or not to send zero-dollar invoices to customer when no premium is due for the month. Current balances due including balances of $0 shall be visible to customers on the issuer's billing and payment portal.

3.8.3 Invoices for Partial Months:

In a situation where a partial month of premium is due, premium and subsidy will be prorated according to federal guidance.

Citations: 45 CFR 155.240(e); 26 CFR 1.36B-5(c)(3)(iii)

3.8.4 Payment Threshold:

Following receipt of the binder payment for the first month which must be paid in full, Vermont issuers may apply a payment threshold policy at their discretion, either a percentage or a dollar amount. Under a payment threshold policy, a customer is considered paid in full with payment above the threshold amount.

Citations: 45 CFR 155.400(g)

3.9 Refunds:

This section includes billing-related policy and operational information for refunds.

3.9.1 For Customers Receiving APTC:

According to federal law, if an Exchange error is discovered resulting in customer overpayment of premium because an incorrect (lower) amount of APTC was applied, the marketplace shall provide notice of the error to the customer. The customer may request that the excess premium be applied toward their portion of premium in subsequent months. Alternatively, the customer may request a full refund of excess premium paid to the issuer, after processing APTC adjustments.

Citations: 45 CFR 155.340(h)(1-2)

3.9.2 For Unsubsidized Customers:

Issuers may establish business practices to resolve instances of overpayment of premium not involving APTC through refunds or credits on customer accounts.

3.9.2.1 Refunds Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
2559	TRANSITIONAL - MMIS System Admin must create a refund screen (using FNF2 as a template) to display VPA history record(s).
2560	TRANSITIONAL - MMIS System Admin must create a refund screen (using FNF2 as a template) to display a VTCSR history record(s).
BR-SUBPAY-00082	A DVHA User must be able to search VHC QHP subsidy refund history.

Section 4: Change of Circumstance

4.1 Overview:

The Vermont health insurance marketplace follows federal and state guidelines for special enrollment periods (SEPs) for prospective new customers to begin coverage or for existing customers to change plans. Eligibility and parameters for SEPs depend upon the individual experiencing a qualifying event as described in the Qualifying Events Chart located in section 4.2.3.6.1 below. This section describes billing-related operational details for new coverage and for coverage changes associated with SEPs as well as certain SEP circumstances where the coverage effective date may be mid-month.

4.2 Special Enrollment Periods and Premium Billing:

4.2.1 New Coverage:

For customers enrolling in new coverage due to a SEP after experiencing a qualifying event, issuers shall send an initial invoice following plan selection. Full payment of the initial premium amount, (binder payment) from the customer, is required to effectuate coverage. The State of Vermont requires the premium date to be a minimum of twenty-one days from the invoice date (VT citation provided below). The effective date of coverage is determined following provisions outlined in the *Qualifying Events Chart*. Without payment of the first month's premium the customer's application for coverage will be cancelled by the issuer as never effective (citation below).

4.2.1.1 Pre-Conditions:

-Customer is not enrolled with coverage

4.2.1.2 Post-Conditions:

-Customer is effectuated with coverage

4.2.2 Coverage Changes:

For customers already enrolled in coverage and who are making changes to existing coverage, or changing plans due to an SEP, any up or down premium adjustment will be reflected in the following invoice including any change to subsidy (citation below). The coverage effective date for the SEP change follows the *Qualifying Event Chart*. In the event that an existing customer experiences a change related to eligibility for subsidy, the Exchange will provide the customer with a notice explaining details of the change.

4.2.2.1 Pre-Conditions:

-Customer is enrolled with coverage but a change needs to be made

4.2.2.2 Post-Conditions:

-Customer is effectuated with updated coverage

4.2.3 Mid-Month Initial Coverage Date or Coverage Change Date:

For customers eligible for a SEP by experiencing a qualifying event of adding a dependent through birth or adoption, or a court order for coverage, the coverage effective date may be mid-month. In the event of death of a subscriber or other household member, coverage terminates for the deceased person on the date of death. Refer to the *Qualifying Event Chart* at the address provided in Section 4.2.3.6.1. In instances where coverage begins or ends mid-month, issuers will send customers an initial invoice for the new coverage reflecting the change, with a pro-rated amount depending on the days of coverage in the partial month. Vermont follows the federal process to calculate premium proration (citation below).

4.2.3.1 Pre-Conditions:

-Customer is enrolled with coverage but needs to change coverage mid-month
-Customer is enrolled with coverage but needs to change coverage date

4.2.3.2 Post-Conditions:

-Customer is effectuated with coverage

4.2.3.3 Change of Circumstance Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
2480	Issuers system must be able to read the 834 CoCs.
2481	Issuers system must be able process the 834 CoCs.
2482	The VHC system must support the sending COC changes for plan years Post-2021 to the Issuers in the subsequent Issuer 834 batch file.
2483	The VHC system must set a payment flag to trigger sending the 834 transaction to the carrier for PYs prior to 2022.
2484	The VHC system must batch Post-2021 QHP enrollment changes to each Issuer.
2567	TRANSITIONAL - The VHC system must support sending COC changes for plan years pre-2022 to WEX Health through the end of 4/30/2022.
BR-CHGCIR-00001	When a pre-2022 QHP enrollment changes in the VHC system, the change will be sent to WEX until 4-30-2022.
BR-CHGCIR-00002	Pre-2022 QHP enrollment changes in the VHC system must be sent to the Issuer.
BR-CHGCIR-00003	Batched VHC QHP enrollment changes must be sent to the plan Issuer each night.
BR-CHGCIR-00004	The VHC system must use Post-2021 834 transaction format as defined in the EDI Companion Document.
BR-CHGCIR-00005	Medicaid protocol will not change, this requirement pertains to QHP-only in the future state for benefit years 2022 onward.
BR-CHGCIR-00006	VHC QHP enrollment changes must be sent only to issuers for plan years after 2021.
BR-CHGCIR-00010	Post 6/1/22, where Issuers will make retro changes to items handled by WEX, Issuers will not reconcile VPA amounts.

4.2.3.3.1 New Coverage Citations:

1. **Initial Invoice: 8 VSA 4089h**
2. **Special enrollment periods: HBEE 71.03**
3. **Qualifying Event Chart for Special Enrollment Periods (SEPs)**: https://info.healthconnect.vermont.gov/report-change/qualifying-events-chart

4.2.3.3.2 Mid-year Coverage Change Citations:

1. **Special enrollment periods: 45 CFR 155.420**
2. **Pro-ration: 45 CFR 155.240(e); 26 CFR 1.36B-5(c)(3)(iii)**
3. **Cancellation**: **45 CFR 155.400(e)**
4. **Customer Notices For Changes in Eligibility**: **45 CFR 155.340(a), 45 CFR 156.460**
5. **Requirements for Invoices to Reflect Subsidy Amount: 45 CFR 156.460(a)**

Section 5: Terminations

5.1 Overview:

This section describes the required billing –related activities associated with various circumstances under which a customer's coverage is ended (terminated). These circumstances include coverage termination for non-payment of premium, a customer's voluntary termination of coverage, termination of QHP coverage after becoming eligible for Medicaid, and termination of coverage due to death. This section also describes the circumstances and billing-related activities related to reinstatement of coverage following termination of coverage.

5.2 Definitions:

Termination. An action taken after a coverage effective date that ends a customer's enrollment through VHC for a date after the original coverage effective date, resulting in a period during which the individual was enrolled in coverage through the Vermont health insurance marketplace. Federal and/or State of Vermont subsidy received by the customer, if any, is terminated concurrently with coverage.

Cancellation. A specific type of termination action that ends a qualified individual's enrollment on the date such enrollment became effective resulting in enrollment never having been effective.

5.2.1 Pre-Conditions:

-Customer never made initial binder payment and was never effectuated.

5.2.2 Post-Conditions:

-Customer continues to not have coverage.

5.3 Reinstatements:

A reinstatement is a correction of an erroneous termination or cancellation action that results in restoration of an enrollment with no break in coverage. Reinstatement may be allowed following full payment after termination for non-payment. Reinstatement may also occur to correct an error on the part of the customer, the issuer, or the Vermont insurance marketplace based on a customer complaint or appeal. Issuer authority to reinstate coverage following erroneous termination for non-payment:

a. Federal: **45 CFR 155.430(e)**

b. Vermont: **HBEE 76.00(e)**

5.3.1 Pre-Conditions:

-Customer had active coverage and was terminated.

5.3.2 Post-Conditions:

-If customer should not have been terminated, they will be reinstated.
-If customer should have been terminated, they will not be reinstated.

5.4 Samples of Various Termination Types:

5.5 Non-Payment:

Termination for non-payment of premium is effective on the last day of the first month of the grace period---one month for unsubsidized customers and three consecutive months for subsidized QHP enrollees.

5.5.1 Pre-Conditions:

-Customer had effectuated coverage but did not make premium payments.

5.5.2 Post-Conditions:

-Customer's coverage is terminated.

5.6 Voluntary:

Although the default rule is that coverage terminates at the end of the month during which a voluntary termination request is made, Federal and State rules provide the customer an option to terminate QHP coverage mid-month with "reasonable notice". The rule defines reasonable notice as at least 14 days from the date of request. Voluntary terminations with an effective date other than the end of a coverage month result in a customer refund following the pro-ration method defined in federal law.

Example: Customer calls 3/10 and requests QHP termination. Default termination date would be 3/31, but the customer could request 3/24 or any date after as a termination date per the rules.

5.6.1 Pre-Conditions:

-Customer has active coverage.

5.6.2 Post-Conditions:

-Customer is terminated based on their request.

5.7 Medicaid Eligibility:

In the event that a customer is determined to be Medicaid eligible and requests termination of QHP coverage, the termination is effective on the last day of the month prior to being determined Medicaid eligible. Prior Medicaid effective dates may result in a customer refund for QHP coverage after the Medicaid effective date. 5.8 Death:

QHP coverage is terminated on the date of a customer's death. In a scenario where the death results in termination of the entire policy (single subscriber) a premium refund is required for the remainder of the coverage month after the date of death using the pro-ration methodology described in federal guidance.

5.7.1 Pre-Conditions:

-Head of Household passes away.
-Non-Head of Household member on policy passes away.

5.7.2 Post-Conditions:

-New policy is created with new Head of Household.

-Non-Head of Household member on policy is removed from policy.

5.7.3 Terminations Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
2529	Issuers must send VHC a notification of termination when they terminate a subscriber's policy.
BR-TERMS-00001	The Issuer's notification of termination must include the Exchange Subscriber Identifier and the last day of coverage.
BR-TERMS-00002	Termination of a subscriber policy applies to all members covered under the subscriber.
BR-TERMS-00003	Issuers must only terminate a subscriber policy for non-payment.
BR-TERMS-00004	Issuers must comply with the State Rules 33 VSA 1811(d)(1) and 8 VSA 4089h for non-payment termination policies.
BR-TERMS-00005	Issuers must comply with the Federal Rule 45 CFR 156.270(d) for non-payment termination policies.
BR-TERMS-00006	Customers must have effectuated coverage before they can be terminated for non-payment.
BR-TERMS-00007	Issuers must process a subscriber's non-pay termination before sending the subsequent month's invoice.
BR-TERMS-00008	Issuer generated 834 non-pay termination must include; Last Day of Coverage for member and member's Exchange Subscriber Identifier.
BR-TERMS-00019	Termination of customers for non-payment of post 2021 plan year premiums must be determined by the Issuers.
BR-TERMS-00020	The SOV may override an Issuer's non-pay termination.
BR-TERMS-00022	A termination is defined as a policy where the end date is a future date from the start date.

5.7.4 Cancellations Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
2609	Issuer systems must be able to receive and process cancellations via 834 for PY 2022 and after.
BR-CANCEL-00002	Cancellation of a Subscriber policy applies to all members covered under the Subscriber.
BR-CANCEL-00003	SoV may override the decision of a previously cancelled policy.
BR-CANCEL-00005	A cancellation is defined as a policy where the start date is equal to the end date.
BR-CANCEL-00006	A non-pay cancellation can only apply to a plan that was never effectuated.
BR-CANCEL-00009	VHC admin must manually effectuate the initial enrollment for a cancelled BCBS member in the transaction log with a mock effectuation.
BR-CANCEL-00011	Issuers will not receive cancellation 834(s) from VHC System for their members who are cancelled in VHC System.

5.7.5 Citations:

5.7.5.1 Termination:

Federal: § 45 CFR § 155.430 (d)(i))

Death: § 155.430 (2)(d)(7)

Vermont: HBEE 76.00(d)

5.7.5.2 Pro-ration:

Federal: § 45 CFR 155.240(e)

Section 6: Renewals

6.1 Overview:

Vermont's health insurance marketplace generally follows the annual open enrollment period defined by CMS. The plan year for qualified plans certified by the Vermont Exchange is defined as the calendar year, January 1 to December 31st. Customers may enroll in any plan for which they meet eligibility criteria, with any Vermont issuer. This section of the guidance describes policies and billing-related operations for invoicing, binder payments, cancellations, and management of grace periods for customers choosing to renew with the same issuer, or with a different issuer. This section also includes renewal information unique to the premium processing transition year, 2021 – 2022, and for renewals from 2022 – 2023 forward.

6.2 Renewals for Customers Remaining with The Same Issuer:

A customer with active coverage is automatically renewed in the same plan with the same insurance issuer for the following coverage (calendar) year. In the event that an enrollee's plan is discontinued, not offered in the renewal year, the enrollee is auto-renewed into the closest equivalent plan identified in a renewal mapping plan approved in advance by the Department of Vermont Health Access (DVHA) and the Vermont Department of Financial Regulation (DFR). During open enrollment, customers may enroll in any plan for which they meet eligibility criteria, with any Vermont issuer.

6.2.1 Transition Period Billing & Grace Periods (2021 – 2022 Only):

Anticipating that customers will require an adjustment period for the transition from centralized premium billing and payment remittance combined for all issuers through the Exchange to individual issuers, processes during the 2021 – 2022 plan years provide extra flexibility. The process described below will vary by issuer depending on system capability; beginning with the 2022 – 2023 renewal period, premium billing and grace period management will be consistent among all issuers.

6.2.2 Grace Periods:

For customers renewing coverage with the same issuer, grace periods spanning plan years continue across plan years.

6.2.3 Subsidized Customers:

A subsidized customer whose first grace period month is November, is enrolled in coverage in the renewal year, and remains unpaid through January (the third month of a 3-month grace period), will have coverage terminated in early February of the renewal year, effective November 30th of the prior year. In this example, the customer's coverage termination impacts both the previous year and the renewal year.

6.2.4 Full Pay Customers:

A full pay customer terminated, for example, in November for an unpaid premium balance in October may apply for coverage in the renewal year, before open enrollment ends. This gap in coverage does not prevent re-enrollment in the renewal year with either the same issuer or a with a different issuer.

A full pay customer with an unpaid premium balance in December, for example, may be terminated effective December 31st following a 30-day grace period. Termination of coverage in this example also causes termination of coverage in the renewal year.

6.2.5 Renewal Invoices:

In December, issuers will send invoices to customers for January coverage in their renewal plan. In the event that a customer selects a different plan with the same issuer after the initial January invoice is mailed in December, a follow up invoice will be sent reflecting the premium amount for the customer's selected renewal plan, plus any past due premium balance.

6.2.6 Binder Payment:

Binder payments are not required to effectuate coverage for customers renewing coverage with the same issuer, even if the customer selects a different renewal plan with the same issuer.

6.2.6.1 Pre-Conditions:

-Customer must have active QHP coverage

6.2.6.2 Post-Conditions:

-Customer must be renewing with same Issuer

6.2.6.3 Renewals with Same Issuer Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
2522	Customer must be able to renew their QHP coverage under a different plan with the same carrier.
BR-RENEWAL-00001	Effective 1-1-2022 a QHP renewal is when a currently enrolled customer enrolls in any plan with the same carrier for the new Plan Year.
BR-RENEWAL-00002	Member QHP renewals only occur within the annual open enrollment period.
BR-RENEWAL-00003	Renewed members are not required to make a binder payment to effectuate QHP coverage.
BR-RENEWAL-00004	Renewed members in a grace period spanning coverage years must pay prior balances to avoid non-payment termination for the prior year.
BR-RENEWAL-00005	Termination for non-payment will cancel any coverage renewed for the new benefit year.
BR-RENEWAL-00006	Payments must be applied to the earliest balance owed for renewed members.
BR-RENEWAL-00007	A new QHP enrollment is when a customer has never been enrolled in a VHC plan for that plan year.

6.3 Renewals for Customers Switching Issuers:

6.3.1 Grace Periods:

Grace periods spanning coverage years for customers choosing renewal coverage with a different issuer are managed separately for the previous coverage year and the renewal coverage year.

6.3.2 Subsidized Customers:

For example, a customer with unpaid coverage beginning in October and continuing for the grace period of three consecutive months unpaid through December, will have coverage terminated in January of the renewal year by the "old" issuer effective October 31st, the last day of the first grace period month. This results in a two-month gap in the customer's coverage of November and December.

The customer's renewal coverage continues in effect with the new issuer. The customer would enter a new grace period of three consecutive months in the event of future missed payments.

6.3.3 Full Pay Customers:

Customers who do not receive premium subsidy are entitled to a one-month grace period.

6.3.4 Renewal Invoices:

January invoices are sent to all existing and new customers in early December with a due date at the end of December. Customers choosing coverage with a different issuer after the normally scheduled invoice batch has been sent, but before the annual open enrollment period ends, will receive a separate invoice following plan selection. In accordance with Vermont law, the payment due date for all invoices must be a minimum of 21 days after the invoice date. For example, an invoice for a customer selecting coverage for the renewal year on December 14 would have a due date in early January.

6.3.5 Binder Payments:

Binder payments are required from customers to be effectuated in coverage for January of the renewal year with a new issuer.

6.3.6 Cancellations:

Issuers may cancel coverage for new customers, including those enrolling in Exchange coverage for the first time and customers renewing coverage with a different issuer, if unpaid approximately one month after the premium due date. Coverage that is never effectuated is cancelled as of January 1; the same day the coverage would have become effective.

6.3.6.1 Pre-Conditions:

-Customer must have active QHP coverage.

6.3.6.2 Post-Conditions:

-Customer must be switching coverage from one Issuer to another.

6.3.6.3 Renewals for Customers Switching Issuers Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
2523	Customer must be able to renew their QHP coverage under a different plan with a different carrier.
BR-RENEWAL-00002	Member QHP renewals only occur within the annual open enrollment period.
BR-RENEWAL-00003	Renewed members are not required to make a binder payment to effectuate QHP coverage.
BR-RENEWAL-00004	Renewed members in a grace period spanning coverage years must pay prior balances to avoid non-payment termination for the prior year.
BR-RENEWAL-00005	Termination for non-payment will cancel any coverage renewed for the new benefit year.
BR-RENEWAL-00006	Payments must be applied to the earliest balance owed for renewed members.
BR-RENEWAL-00007	A new QHP enrollment is when a customer has never been enrolled in a VHC plan for that plan year.
BR-RENEWAL-00008	Effective 1-1-2022 a QHP renewal with a different Issuer for the new Plan Year is considered a new enrollment with that Issuer.

6.4

Citations:

Vermont Citation (Guaranteed Issue): **33 VSA 1811(d)(1)**

Federal Citation (Guaranteed Renewability): 45 CFR 147.106(b)(1)

Federal Citation (Grace Periods for Subsidized Individuals): 45 CFR 156.270(d)

Vermont Citation (Grace Periods for Unsubsidized Individuals): 8 V.S.A 4077

Section 7: Customer Complaints

7.1 Overview:

Customers with questions or complaints related to premium billing (premium amount, balance due, payment receipt, late payment notices, grace periods, terminations for non-payment, reinstatements following erroneous termination) must contact their issuer. It is expected that the vast majority of billing-related questions or issues will be resolved in the initial inquiry process through issuers. In the event that an enrolled customer is dissatisfied with the issuer's resolution of a question or issue, customers may file a complaint with the Vermont Department of Financial Regulation (DFR) through its consumer complaint process. DFR will document the complaint, may contact the issuer for additional information, and determine the appropriate final resolution of the issue which may or may not align with the issuer's initial response.

For customers enrolled through the Vermont health insurance marketplace, questions involving enrollment and subsidy eligibility, should be directed to Customer Support at Vermont Health Connect. Most eligibility and enrollment questions and issues will be resolved in this initial inquiry process through Customer Support. In addition, customers may file a formal appeal for review and final determination through the Vermont Human Services Board (HSB). These cases are processed by DVHA's

Health Care Appeals Team (HCAT) and reviewed through a process of fact-gathering followed by a formal hearing. The HSB issues its findings on individual cases through an order determining actions for the Exchange, an issuer and/or a customer must take for resolution of the case.

Many subsidy eligibility questions and issues from customers will also result in billing questions, so it may be unclear to customers who they should contact with their questions: the Vermont insurance marketplace, or their issuer. Workflows have been designed to provide an efficient and smooth customer experience with referral to the appropriate entity for initial review and resolution of issues regardless of where the customer inquiry begins.

Federal and State of Vermont References:

1. DFR authority to review customer complaints: **8 V.S.A. § 4089f**.
2. Issuer authority to manage customer billing and associated customer inquiries: **45 C.F.R. § 147.136**
3. **HBEE Part 8**
4. Issuer authority to reinstate coverage following erroneous termination for non-payment:
    a. **Federal: 45 CFR 155.430(e)**
    b. **Vermont: HBEE 76.00(e)**

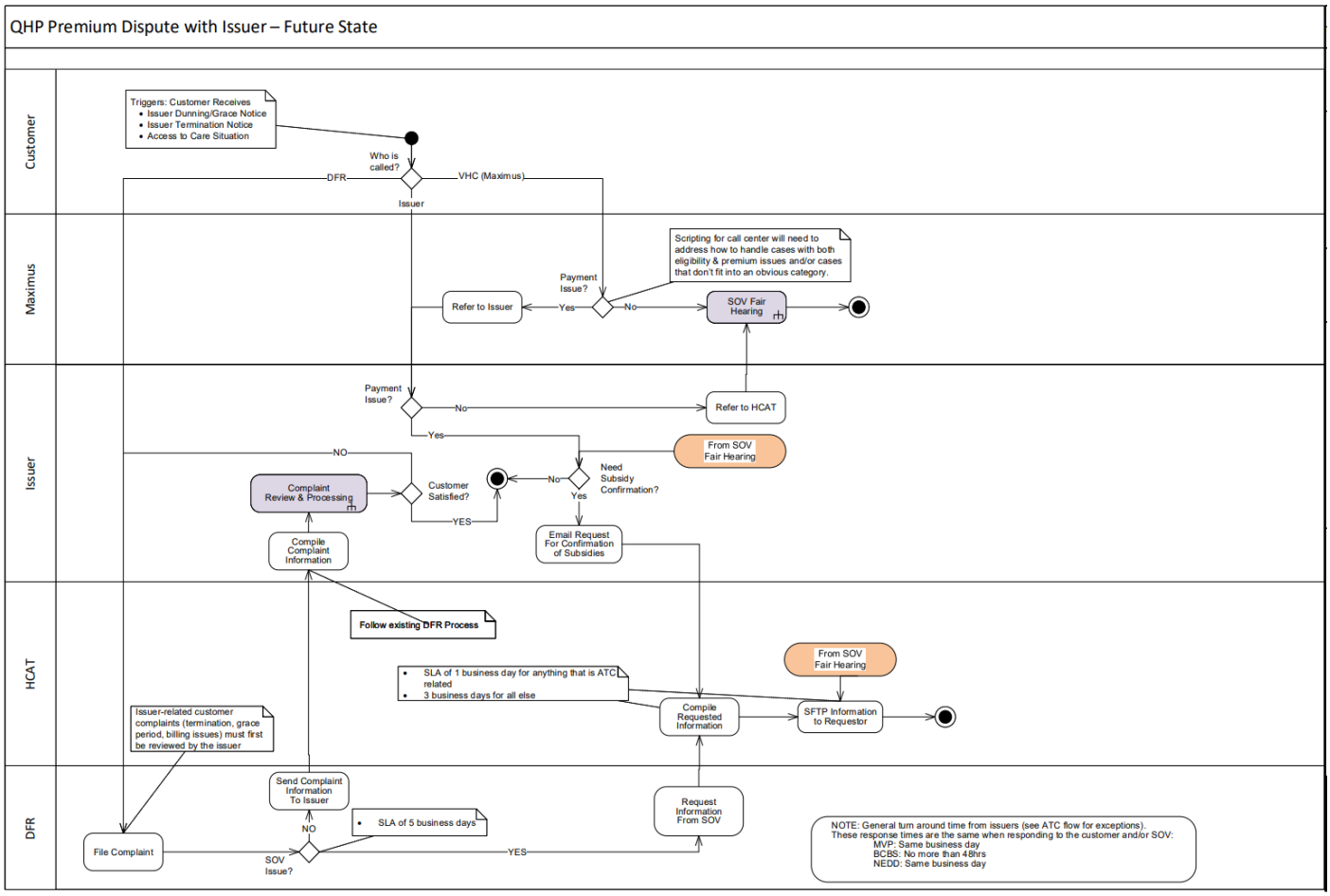
7.1.1 Pre-Conditions:

- Customer is dissatisfied with a decision or resolution related to their case.
- Customer was terminated in error by the SoV

7.1.2 Post-Conditions:

- Customer resolves payment dispute with issuer
- Customer enters appeals and fair hearing process for non-payment related disputes

7.1.3 Customer Complaints Future State Process Flow:



7.1.4 Customer Complaints Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
BR-ISSUERDISP-00001	HCAT must compile and send any information related to ATC cases within 1 business day. Reference SOP for Fair Hearings and Expedited Administrative Appeals of Eligibility Determinations.
BR-ISSUERDISP-00002	DFR will respond to an issuer dispute within 5 business days
BR-ISSUERDISP-00003	HCAT must complete their review of non-payment related issuer disputes in 3 business days. Reference SOP for Fair Hearings and Expedited Administrative Appeals of Eligibility Determinations.

7.2 Fair Hearing:

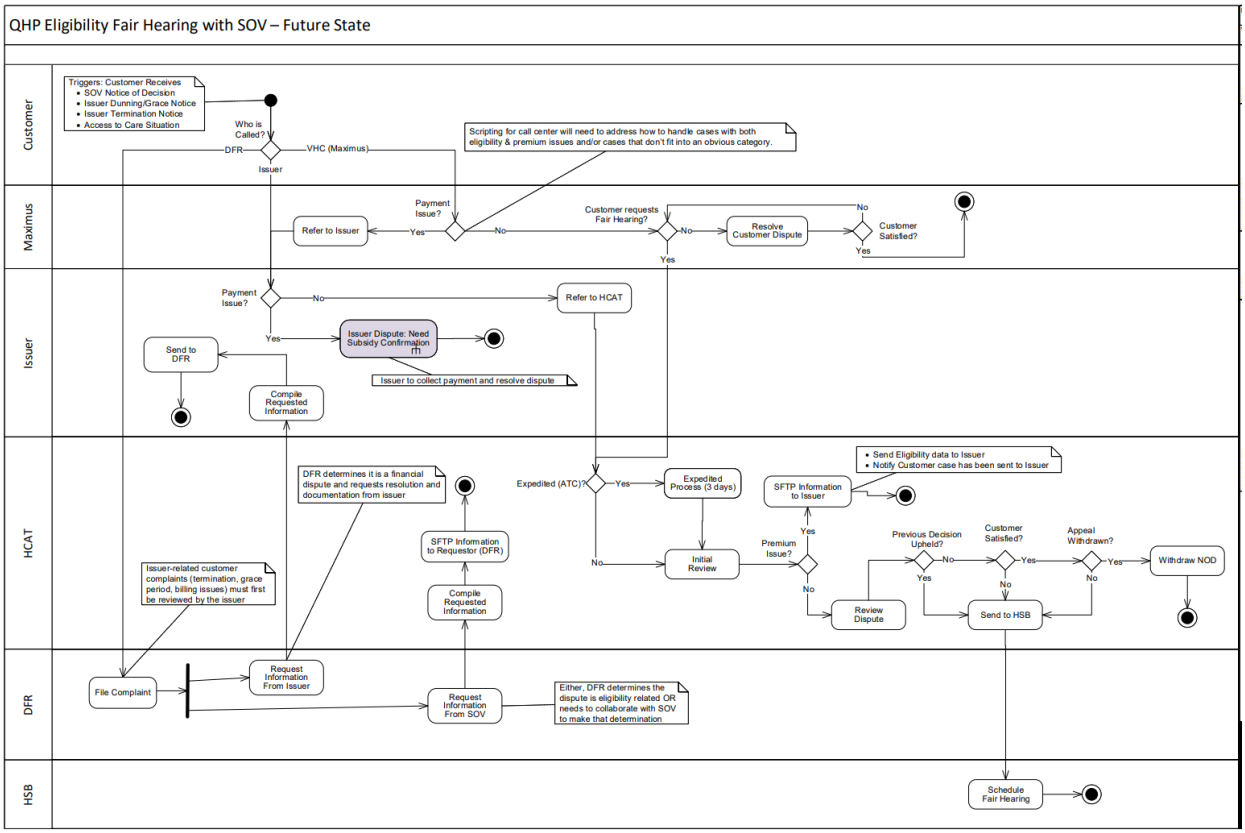
7.2.1 Pre-Conditions:

- Customer is dissatisfied with a decision or resolution related to their case.

7.2.2 Post-Conditions:

- Customer has done one of the following:
  - Satisfactorily resolved the issue(s) related to their case with SoV.
  - Scheduled a fair hearing.
  - Accepted their notice of decision and withdrawn their appeal.

7.2.3 Fair Hearing Future State Process Flow:



7.2.4 Fair Hearing Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
BR-FHEARING-00001	Payment disputes must be referred to the issuer.
BR-FHEARING-00002	HCAT must complete an expedited fair hearing case within 3 business days. Reference SOP For Fair Hearings and Expedited Administrative Appeals of Eligibility Determinations.
BR-FHEARING-00003	Cases for which the decision is upheld after HCAT review and for which the customer is not satisfied nor withdrawing their appeal, must be escalated to HSB for the scheduling of a fair hearing. Reference SOP for Fair Hearings and Expedited Administrative Appeals of Eligibility Determinations.
BR-FHEARING-00004	When a customer withdraws their appeal, the NOD must also be withdrawn. Reference SOP for Fair Hearings and Expedited Administrative Appeals of Eligibility Determinations.

BR-FHEARING-00005	HCAT must review all non-payment related appeals and disputes. Reference SOP for Fair Hearings and Expedited Administrative Appeals of Eligibility Determinations.

7.3 ACCESS TO CARE (ATC):

Access to care (ATC) cases require resolution of an enrollment issue for a customer to receive services or medications immediately. ATC cases have expedited service level standards of resolution within 24 hours for MVP & NEDD (72 hours for BCBS), and often require coordination between issuers and the Exchange customer service teams.

7.3.1 Access to Care Related Business Rules & Functional Requirements:

Req ID or BR ID	Formal Re-Write
BR-ATC-00001	SOV must send the issuer an email (ATC Notification Email) notifying them of an ATC case forthcoming on the next business days 834 file
BR-ATC-00002	SOV must send the issuer ATC customer enrollment data on the 834 file within 24 hours of escalation of the case.
BR-ATC-00003	SOV's ATC notification email to BCBS must include the following data: ICP, Contact ID, start date, & expected BGN#, indication that it is an ATC issue for EACH ATC customer
BR-ATC-00004	SOV must send the ATC notification email to the issuer on the same day that the ATC call from the customer was received.
BR-ATC-00005	Issuer must send SOV an email containing the Member's ID once the ATC case has been resolved.
BR-ATC-00011	The issuer must send SOV member effectuation data within one business day of the resolution of the ATC case.
BR-ATC-00012	Issuer must process ATC cases within 1 business day of receiving the relative 834 file from SOV.

Approvals

Name	Title	Signature
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